Nos. 93-1408, 93-1414 and 93-1415

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*

MARIO M. CUOMO, GOVERNOR OF NEW YORK, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE COMPANY, *et al.*

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner

v.

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On Writs of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE NATIONAL CARRIERS' CONFERENCE COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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ISSUE PRESENTED

We devote this brief to an issue upon which the Court granted *certiorari* but that neither petitioners nor the United States as *amicus curiae* have briefed. That issue is whether New York's 13% surcharge upon all hospital bills paid by, *inter alia*, self-insured plans and plans insured by commercial insurers, but not upon bills paid by plans insured by the Blues, is preempted by § 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), as to self-insured ERISA plans, as distinct from commercially insured ERISA plans.

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BRIEF OF THE NATIONAL CARRIERS' CONFERENCE COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

STATEMENT OF INTEREST

The National Carriers' Conference Committee ("NCCC") submits this brief as *amicus curiae* urging affirmance of the decision of the court of appeals. Pursuant to Rule 37.3 of the Rules of this Court, the NCCC has filed with the Clerk the written consents of all of the parties in this case to the submission of this *amicus curiae* brief.

The NCCC, consisting of labor relations officials of ten of the nation's major freight railroads and the Chairman of the National Railway Labor Conference, is the sole governing body of fiduciaries for The Railroad Employees National Early Retirement Major Medical Benefit Plan. In addition, along with the Health and Welfare Committee of Cooperating Railway Labor Organizations, the NCCC serves as the governing body of fiduciaries for The Railroad Employees National Health and Welfare Plan. These Plans (the "Railroad Plans" or the "Plans") were established and are maintained pursuant to national collective bargaining agreements under the Railway Labor Act between most of the Class I line haul rail carriers in the United States and the principal twelve railway labor organizations. The Plans are self-insured employee welfare benefit plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). They provide health care benefits, including coverage for inpatient hospital care, to more than a half million railroad employees, retirees, and their dependents throughout the country. Respondent The Travelers Insurance Company ("Travelers") provides claims administrative services to the Railroad Plans and acts as a fiduciary of the Plans under §§ 3(21)(A) and 503(2) of ERISA, 29 U.S.C. §§ 1002(21)(A) and 1133(2).

In this case, the court of appeals affirmed the summary judgment of the district court that ERISA preempts the imposition of, among other things, a 13% surcharge under § 2807-c(1)(b) of the N.Y. Pub. Health Law on general hospital bills for inpatient care paid by ERISA-

covered plans, whether such plans are self-insured by the employers maintaining them or insured under a policy issued by a commercial insurer. Reversal of the court of appeals' decision would require the Railroad Plans either (a) to pay the 13% surcharge—approximately $1 million per year—so as to remain self-insured on a national basis as called for by the collective bargaining agreements pursuant to which the Plans are maintained and to continue to have the Plans administered on a national or regional basis by administrators of their choice, or (b) to avoid the 13% surcharge by becoming insured with Blue Cross/Blue Shield (the "Blues") in New York, thus destroying the interstate uniformity of the Plans' structure (self-insured) and administration (nationwide or regional) and subjecting the Plans to New York's host of insurance laws and regulations.

The interest of the NCCC, as fiduciaries of the Plans, is to escape this Hobson's choice.

SUMMARY OF ARGUMENT

I. This case presents two closely related questions: Does ERISA preempt New York's 13% surcharge on hospital bills for inpatient care as the surcharge is applied to ERISA-covered plans that are (a) insured by commercial insurers or (b) self-insured. We contend, contrary to the suggestion of the United States, that the question of ERISA preemption of the surcharge as applied to self-insured plans is properly before the Court and that sound judicial policy calls for its resolution in this case.

The issue of whether ERISA preempts application of the surcharge to self-insured plans has been raised, argued before and decided by both the district court and the court of appeals. Plaintiffs, acting as claims fiduciaries for self-insured plans, raised the issue in their complaints and motions for summary judgment. The district court granted summary judgment in plaintiffs' favor in all respects as to the 13% surcharge, and the court's opinion shows that

the judgment included a declaration that ERISA preempted the surcharge as applied to self-insured plans. Indeed, following the entry of a stay of its judgment on the 13% surcharge pending appeal, the district court ordered the plaintiffs who are claims fiduciaries for self-insured plans to pay the surcharge on their behalf.

Appellants brought the issue regarding self-insured plans to the court of appeals both in their statements of questions presented and in their briefs. In fact, appellant Hospital Association of New York ("HANYS") unsuccessfully opposed the motion of this *amicus* for leave to file a brief in the court of appeals on the ground that the appellees who are claims fiduciaries for self-insured ERISA plans had adequately represented the interests of those plans. The court of appeals affirmed the district court's ruling as to the 13% surcharge in all respects. That the court's opinion did not distinguish between insured and self-insured plans is without consequence, since its ruling found preemption as to both.

All of the petitioners in this Court based their argument for *certiorari* on an alleged conflict between the decision below and the decision of the Third Circuit Court of Appeals in *United Wire, Metal and Machine Health and Welfare Fund* v. *Morristown Memorial Hospital,* 995 F.2d 1179 (3d Cir.), *cert. denied,* 114 S. Ct. 382 (1993), where *only* self-insured plans and their participants challenged various New Jersey hospital rate laws on ERISA preemption grounds. Indeed, the *certiorari* petition of HANYS explicitly framed the issue in terms of whether ERISA preempted New York's different "set of [hospital] rates for patients covered by[, among others,] self-insured plans." Brief for Petitioner HANYS on Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at (i); *HANYS* v. *Travelers Ins. Co.,* Dkt. No. 93-1415, 63 U.S.L.W. 3282, 3291 (U.S. Oct. 7, 1994).

This Court should decide the issue of preemption as to self-insured plans because it is inextricably linked to the

issue of preemption as to insured plans. In both contexts, the impact of the 13% surcharge on a plan's choice of insurers must be evaluated. The preemption issue as to self-insured plans raises two additional, but related, considerations: imposition of the surcharge directly upon an ERISA plan and its effect on a plan's choice of a basic structure, *i.e.*, insurance versus self-insurance. Moreover, the Court should decide the question of preemption of the 13% surcharge as it applies to self-insured plans because that question was the very issue creating the conflict petitioners cited in seeking *certiorari*.

II. The 13% surcharge as applied to self-insured ERISA plans "relates to" them for purposes of ERISA's preemption provision because (a) self-insured plans themselves pay the surcharge to the hospitals—there is no intervening insurance company that pays the hospital and passes the surcharge through to the plans in the form of higher premiums—and (b) the surcharge applies to self-insured plans solely by virtue of the central function that makes them ERISA-covered plans—the payment of health care benefits. This particular characteristic of the surcharge distinguishes it from state laws imposing directly upon self-insured plans requirements affecting the plans by reason of their property ownership, utility use, hiring of employees and other similar activities.

In addition, the surcharge "relates to" the self-insured plans because it is designed to induce them to alter drastically their basic structure and administration by changing from self-insurance administered on a national or multistate regional basis by entities of their choice to insurance with the Blues in New York. Such a change would create severe administrative burdens for such plans and subject them to New York insurance laws and regulations from which Congress, in the "deemer" clause of ERISA's preemption provision, expressly protected them. Furthermore, becoming insured with the Blues in New York would interfere with the uniform plan structure and

administration throughout the country or multistate region that is the hallmark of interstate plan operations, especially those of national plans that are collectively bargained, as are the Railroad Plans.

The insurance "saving" clause of ERISA's preemption provision does not preserve the 13% surcharge from preemption. The surcharge is a law regulating hospital rates, not insurance. Furthermore, the deemer clause of the preemption provision precludes application of the saving clause to any state law to the extent that it "relates to" self-insured plans. Thus, since the 13% surcharge "relates to" self-insured plans, the saving clause does not insulate the surcharge from preemption as it applies to them.

ARGUMENT

New York's effort to improve the competitive position of the Blues by imposing a 13% surcharge on other payors of inpatient hospital bills penalizes both commercially insured and self-insured plans. In the case of insured ERISA plans, the impact of the surcharge comes by way of premium increases by the insurers. In the case of self-insured ERISA plans, the impact is direct and immediate. The surcharge is paid to the hospitals by the plans themselves. Though the aim of the statute is the same in both situations—to induce plans to switch to the Blues "by giving the Blues a competitive advantage over commercially insured, self-insured funds" and others (Pet. App. at 27, 56)[1]—and while in our view a statute so designed runs afoul of ERISA's preemption provision whether applied to commercial insurers or to self-insured plans, the situations are not identical. As the United States acknowledges: "Application of the 13% surcharge

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[1] We adopt "Pet. App." to refer to the Petitioners' Appendix to their petition for *certiorari* in Docket No. 93-1414 and "JA" to refer to the Joint Appendix filed by Petitioners with their briefs on the writ.

to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." Brief for the United States as *Amicus Curiae* Supporting Petitioners at 12 n.3 (hereinafter "Gov't Br."); Brief for the United States as *Amicus Curiae* on Petitions for a Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at 14 n.5 (hereinafter "Gov't Br. on Pet.").

The United States thus appears to appreciate that the argument that the 13% surcharge "relates to" ERISA plans is stronger where the surcharge is levied upon the plan itself than where the surcharge impacts the plan through the intermediary of an insurer. Moreover, in the case of self-insured plans, there is an additional distinguishing factor relating to the plan's basic structure and administration. Not only does the statute designedly color the plan's choice of insurance carrier, but it also affects the choice of insurance as against self-insurance.

In view of the interrelationship of the issues respecting insured and self-insured ERISA plans—both their similarities and dissimilarities—it would on the face of it seem desirable for the Court to examine them together. Nevertheless, petitioners do not discuss the discrete problems raised by application of the surcharge to self-insured plans, and the Government expressly declines to brief the question, resting on its suggestion that the Court remand that issue to the lower courts if it reverses the court of appeals respecting exaction of the surcharge from commercially insured ERISA plans. Gov't Br. at 12 n.3, 28 n.20.

In this brief, we show, first, that the Government's recommendation is grounded in a demonstrably mistaken understanding of the proceedings below and, to the extent it speaks to the Court's discretion, is unwise. We then show that application of the surcharge to self-insured ERISA plans is barred by ERISA's preemption provision.

I. THE QUESTION OF WHETHER OR NOT ERISA PREEMPTS APPLICATION OF NEW YORK'S 13% SURCHARGE TO SELF-INSURED ERISA PLANS IS PROPERLY BEFORE THE COURT AND SHOULD BE DECIDED.

Notwithstanding the Solicitor General's expressed doubts, the issue of preemption of the surcharge as applied to self-insured ERISA plans was unquestionably raised, argued, and decided both in the district court and the court of appeals and was one of the issues as to which this Court granted *certiorari.* Because of the importance of this question and the irreconcilability between our view of the lower court proceedings and the Solicitor General's, we include in the Appendix ("App.") detailed citations to the record in the lower courts. In summary, that record shows the following:

The issue of preemption respecting self-insured plans was raised in the district court by the plaintiffs as fiduciaries for such plans. While the Government, in its Brief as *Amicus Curiae* in support of the petition for *certiorari,* maintained the contrary (Gov't Br. on Pet. at 14 n.5), it now acknowledges, though rather elliptically, its error.[2] Gov't Br. at 11-12 n.3. As to the proceedings before the district court, the affidavits from the plaintiffs in support of their motions for summary judgment were replete with references to self-insured plans, App. at 2a, and the district court granted those motions in all respects pertaining to the 13% surcharge. Pet. App. at 89-90. Moreover, the court in its opinion made quite clear that

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[2] It now says, "In fact, the complaints filed in this case may be read to allege that one or more of the plaintiffs is a self-insured plan, see J.A. 93, at ¶ 18, and the complaints allege that several of the insured-[sic] plaintiffs in this case are fiduciaries for self-insured funds that are ERISA plans, see J.A. 69, 91-93." Gov't Br. at 12 n.3. To say that parties alleged standing to raise an issue is not quite the same thing as to concede that they did in fact raise the issue. But since in fact they did, this seems close enough to be taken as a concession.

its judgment applied to self-insured plans. Thus, the court specifically held, citing *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), that the insurance saving clause of ERISA § 514(b)(2)(A) cannot save the surcharge *as applied to self-insured plans* because "self-insured plans do not engage in the 'business of insurance' as a matter of law." Pet. App. at 79.

The Solicitor General believes it is "not clear" that the district court's injunction—which was directed " 'against any commercial insurers or HMOs in connection with their coverage of any ERISA plans' "—extended to insurers in their capacity as administrators of self-insured plans. Gov't Br. at 12 n.3 (citation omitted). But it is the court's judgment that is controlling, and that judgment plainly extended to self-insured plans. In any event, the Solicitor General's doubt is unfounded. He evidently believes that the term "coverage" in the injunction might refer only to insured coverage. But the court held that HMOs are not engaged in the business of insurance (Pet. App. at 79 & n.14), and, accordingly, the court's use of the term "coverage" respecting both HMOs and commercial insurers must be taken to include coverage under self-insured plans that they administer.

Moreover, the court removed any possible question by squarely ruling, in a post-judgment order of which the Solicitor General may be unaware, that the court's judgment encompassed self-insured plans. After the court had stayed that judgment as to the 13% surcharge pending appeal, a dispute arose as to whether a plaintiff, Travelers, in its capacity as fiduciary for two self-insured ERISA plans that were not parties, the Railroad Plans, was obliged to pay the surcharge on their behalf. Noting that "two self-insured ERISA plans for which Travelers provides administrative services . . . had instructed Travelers not to pay the 13% differential," the court ordered Travelers to pay. App. at 4a-5a and Ex. 8 thereto.

As to the appeal, the Solicitor General says:

> "Since no cross-appeal was taken from the district court's order, the application of the 13% surcharge to 'self-insured fund[s]' was not raised by any party before the court of appeals. Nor did the court address it *sua sponte*." Gov't Br. at 12 n.3.

The Solicitor General is mistaken. (Not, to be sure, with respect to the absence of a cross-appeal regarding any surcharge. But this is a fact without any significance that we can discern, since the judgment on the surcharges was wholly in plaintiffs' favor.) The appeal carried to the court of appeals that judgment, which covered the 13% surcharge as applied to self-insured funds. The appellants' statements of questions presented embraced that issue. And it was briefed by the parties. (See App. at 5a-6a, especially the citations to passages in the appellants' briefs.) Of particular significance is the opposition of appellant—here petitioner—Hospital Association of New York State ("HANYS") to this *amicus*' motion, subsequently granted, for leave to file a brief with the court of appeals:

> "First, the Court already has been favored with briefs from five sets of parties and from four amicus curiae, covering all of the issues. *In particular, the interests of all self-insured plans, and the Railroad Plans specifically, are alrready represented.* Plaintiff the Travelers Insurance Company ('Travelers') acts as fiduciary or otherwise provides administrative services to self-insured plans, including the Railroad Plans. Travelers has specifically lodged its complaint in such capacity. (Citation omitted.) The additional brief which the Railroad Plans seek to submit is merely cumulative . . . ." (Emphasis added.) App. at 7a and Ex. 9 thereto.

Thus the issue as to self-insured plans was clearly in play in the court of appeals; and while the court did not in its opinion distinguish between self-insured plans and insured plans, there was no reason for it to do so. App.

at 8a. The court simply referred to the 13% surcharge in general terms without distinction as to payor—whether commercial insurer or self-insured plan—and if its rationale be thought to be framed primarily with reference to insured plans, that rationale surely applied *a fortiori* to self-insured plans. If anything can be said to be missing, it is simply the equivalent of an addendum stating that "the same is true of self-insured plans".[3]

In this Court, the petitioners sought review of the judgment below insofar as it struck down the 13% surcharge and did not, naturally, excise from their request that element of the judgment applying to self-insured plans. To the contrary, the first issue identified in the petition filed by HANYS expressly raised the question of preemption of New York's different "set of [hospital] rates for patients covered by[, among others,] self-insured plans," and the Court granted that petition as to that issue. Brief for Petitioner HANYS on Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at (i); *HANYS* v. *Travelers Ins. Co.*, Dkt. No. 93-1415, 63 U.S.L.W. 3282, 3291 (U.S. Oct. 7, 1994). Moreover, the principal reason advanced by all petitioners for review was the asserted conflict between the decision below and that of the Third Circuit Court of Appeals in *United Wire, Metal and Machine Health and Welfare Fund* v. *Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir. 1993)—a case where *only self-insured plans and their participants* challenged various New Jersey hospital rate laws as preempted by ERISA.

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[3] If a full expression of the court of appeals' views respecting preemption as it applies to self-insured plans be thought helpful, the court supplied it in its subsequent opinion in *NYSA-ILA Medical and Clinical Services Fund* v. *Axelrod*, 27 F.3d 823 (2d Cir.), *petition for cert. filed sub nom. Chassin* v. *NYSA-ILA Medical and Clinical Services Fund*, 63 U.S.L.W. 3429 (U.S. Oct. 21, 1994) (No. 94-745).

In these circumstances, the Solicitor General's suggestion that the Court not decide the preemption issue as it relates to self-insured plans is without procedural warrant. It is also without merit as a matter of judicial policy. That issue is inextricably linked to the issue of preemption respecting insured plans. A central element of the preemption analysis respecting the surcharge's application to ERISA plans generally is the New York statute's purpose of influencing the plans' choice of insurers. That element must be evaluated as it relates to insured plans. It is even more pertinent in the context of self-insured plans, because that context includes two additional, but related, factors—the effect on the choice of a plan's basic structure, *i.e.*, self-insurance versus insurance, and the direct imposition of the surcharge on the plans. There is no sound reason for excluding self-insured plans from this assessment and leaving undecided the very question answered in *United Wire* that petitioners asserted created the conflict requiring resolution by this Court. This is especially so because, as we have noted *supra* at 11 n.3, that question was ruled upon by the Court of Appeals for the Second Circuit in a decision subsequent to the one here under review, a decision as to which a petition for *certiorari* is currently pending.

We add that it might be useful to the Court to be advised of the position of the United States respecting self-insured plans. In the court below, as the Solicitor General notes, the Secretary of Labor, appearing as *amicus curiae*, took the position "that the impact on choices made by plans provides a sufficient connection to trigger preemption" of the surcharges on the ground that they "relate to" ERISA plans, "but that—except for self-insured ERISA plans, which are protected by the 'deemer' clause—they are saved from preemption by the insurance savings clause." Gov't Br. at 14 n.4. The Secretary has now joined in the contrary position expressed in the brief for the United States with respect to insured plans, *id.* at 14 & n.4; but there is no indication that the United States

would extend that reversal of position to self-insured plans, which, the Solicitor General acknowledges, "may raise some distinct issues." *Id.* at 12 n.3.

II. SECTION 514(a) OF ERISA PREEMPTS APPLICATION OF NEW YORK'S 13% SURCHARGE TO SELF-INSURED ERISA PLANS.

New York's 13% surcharge as applied to self-insured ERISA plans "relates to" those plans for purposes of § 514(a) of ERISA, 29 U.S.C. § 1144(a), and, as applied to those plans, is not a law "which regulates insurance" under the saving clause of § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

A. The "Relates to" Clause.

The 13% surcharge imposed upon self-insured ERISA plans "relates to" them for purposes of § 514(a) because the surcharge is a *direct* levy upon such plans and attaches to the very activity that makes them ERISA-covered plans, the provision of health care benefits to plan participants. The plans pay the surcharge to the billing hospital; there is no intervening insurance company that pays the hospital and passes the surcharge on to the plans in the form of higher premiums.[4] And the provision of hospital care benefits to participants, the activity upon which the surcharge is fixed, is the very function that brings the plans, pursuant to § 3(1) of ERISA, 29 U.S.C. § 1002(1), under its coverage.

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[4] The distinction is not merely formal. When paid by ERISA plans in response to the hospital's bill, the amount is fixed by law. When passed through by a commercial insurer, the amount is determined by the realities of the competitive marketplace. Insurers must cover their costs or go out of business. Accordingly, substantial cost increases suffered by the insurer are almost certain to increase the costs of the insured plan. Still, the difference between a cost increase that the law requires a self-insured plan to pay and a cost increase that an insured plan is asked by its insurer to agree to pay is a real difference.

We submit that these facts, viewed against this Court's rulings that ERISA's preemption clause is to be accorded " 'its broad common-sense meaning,' " *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 47 (1987) (citations omitted), so as to give "effect to the 'deliberately expansive' language chosen by Congress," *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992) (citation omitted), make inescapable the conclusion that New York's 13% surcharge "relates to" self-insured ERISA plans. As in *Mackey* v. *Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the result is driven by the statutory language. To borrow and adapt the words of *amicus curiae* quoted by this Court in *Mackey* in applying the "relates to" phrase, " 'there is simply no logical way to construe the English language' " so as to conclude that a law imposing a 13% levy on bills paid by self-insured ERISA plans for inpatient hospital care of plan participants does not "relate to" such plans. *Mackey*, 486 U.S. at 836.

This is not to say that *any* tax or other requirement directly imposed upon an ERISA plan "relates to" that plan for purposes of § 514(a). Congress did not intend to wipe out a state's entire body of laws insofar as they apply to ERISA plans. As the Court observed in considering state judicial remedies in *Mackey*, no one would contend that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are preempted. *Id.* at 833. But here, the 13% surcharge is not only imposed directly upon self-insured plans, *it is imposed solely by virtue of the core plan function that causes the plan to fall within ERISA's ambit, the provision of health care benefits to plan participants.*

On this analysis, the term "relates to" would retain the exceedingly broad meaning that Congress intended and that this Court has articulated. It would not be artificially constricted so as to avoid unreasonable results. Such results would be avoided, instead, through interpretation

of the phrase "any employee benefit plan"—to which the challenged state law must "relate"—so that that phrase does not simply describe one type of enterprise among others, but defines an entity that is affected by the state law *because it is a benefit plan* rather than something else. Laws that apply to ERISA plans, then, solely because they own property, or use utilities, or hire employees, or engage in other activities just as do myriad other enterprises, would not "relate to" those plans even though the laws impose requirements directly upon the plans.

In short, because it is imposed directly on self-insured ERISA plans and targets their provision of health care benefits, the 13% surcharge for those reasons alone "relates to" those plans for purposes of § 514(a).[5] This, we submit, is the teaching of the two decisions of this Court holding state laws preempted as applied directly to self-insured ERISA plans by virtue of their performance of their core functions. In *Shaw* v. *Delta Air Lines, Inc.*, 463 US. 85 (1983), The Court ruled preempted a state statute prohibiting discrimination in employee benefit plans on the basis of pregnancy.[6] While the law did not apply only to ERISA plans, the Court had "no difficulty in concluding" that it "relate[d] to" such plans because it "pro-

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[5] Accordingly, the surcharge cannot be listed as among those laws of "general applicability" that this Court has noted may be more likely than other laws to have a "tenuous, remote or peripheral" effect on ERISA plans. *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 n.1 (1992). Rather, the surcharge is primarily addressed to and primarily affects ERISA plans. It is assessed upon a limited category of payors of hospital bills, and there can be little doubt that the vast majority of payments to hospitals by entities in this category are made either by insured or self-insured plans subject to ERISA. Hence, the 13% surcharge is hardly "generally applicable" even to all payors for hospital services, no less the population at large.

[6] For an explication of the Court's ruling as to a second statute involved in *Shaw*, see *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 585 (1992).

hibit[ed] employers from structuring their employee benefit plans" in a certain manner. Id. at 96-97. And in *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), the Court ruled that § 514(a) applied to a state law barring both ERISA and non-ERISA plans from asserting subrogation with respect to a beneficiary's tort recovery.[7] Any number of decisions in the courts of appeals are of similar import. See, *e.g.*, *Travitz* v. *Northeast Dep't ILGWU Health and Welfare Fund*, 13 F.3d 704, 709-10 (3d Cir. 1994) (state bar against recovery from tortfeasor of amounts otherwise payable by self-insured plan "relates to" that plan); *Auto Club Ins. Ass'n* v. *Health and Welfare Plans, Inc.*, 961 F.2d 588, 592-93 (6th Cir. 1992) (state coordination of benefits rule, as applied to self insured plans, "relates to" them); *Mullenix* v. *Aetna Life and Casualty Ins. Co.*, 912 F.2d 1406, 1408-09 (11th Cir. 1990) (application to self-insured plans of state mandate that chiropractic services be covered "relates to" such plans); *Brown* v. *Granatelli*, 897 F.2d 1351, 1353-55 (5th Cir. 1990) (application to self-insured plans of state requirement that health insurance policies cover newborns with congenital defects "relates to"

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[7] Other § 514(a) decisions by the Court accord with this analysis. In three cases, the challenged state laws did not apply directly to ERISA plans, but the Court held them preempted nonetheless because there was a substantial indirect impact that bore specifically on the plans' activities in providing benefits. *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990); and *Greater Washington Board of Trade*, 113 S. Ct. 580 (1992). In a fourth case, on the other hand, the Court upheld state laws that impacted ERISA plans only indirectly and that did not impinge upon interests, such as uniformity, that ERISA was designed to secure. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987). Finally, in *Mackey*, 486 U.S. 825 (1988), while the state law—a general garnishment statute—did apply directly to ERISA plans, it was not aimed specifically at the activities they conducted because they were benefit plans. In any event, the Court viewed other ERISA provisions as evidencing a legislative intent under which such statutes were permissible. For a similar ruling, see *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

such plans even if they have purchased stop-loss insurance); *PPG Indus. Pension Plan A (CIO)* v. *Crews*, 902 F.2d 1148, 1150-51 (4th Cir. 1990) (state law prohibiting particular method of integrating pension and workers' compensation benefits as applied to self-insured plans "relates to" such plans); *Baxter* v. *Lynn*, 886 F.2d 182, 185 (8th Cir. 1989) (state law that "prohibit[s] employers from structuring their [self-insured plans] in a manner that requires reimbursement" by plan participant who recovers from third-party "relates to" such plans).[8]

There is in addition a further reason why New York's 13% surcharge "relates to" self-insured plans: It is designed to induce them, although they may be nationwide and collectively bargained, as are the Railroad Plans, to change their basic structure and administration—from self-insurance administered on a national or multistate regional basis by the entity of their choice to insurance with the Blues in New York.

A primary goal of the 13% surcharge when enacted was to encourage providers of health care benefits, be they commercial insurers or self-insured plans, to insure those benefits with the Blues. The court of appeals found that the surcharge "was meant to ' "level [the] playing field" ' for the Blues . . . (citations omitted). The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues." JA 37. See also Gov't Br. at 9 (the surcharges "are *designed* to give the Blues a rate advantage in the marketplace, thereby encouraging more customers to purchase coverage from the

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[8] The decision of the Third Circuit Court of Appeals in *United Wire*, 995 F.2d 1179 (3d Cir. 1993), appears to depart from this approach. We think it incorrect, but in any event, as we hereafter note in the text, the 13% surcharge is materially different from, and more pernicious than, the laws involved in *United Wire* in that New York's surcharge designedly interferes with a plan's determination of what its basic structure and administration should be.

Blues and helping maintain the solvency of the Blues." (Emphasis added.)).

By penalizing self-insured plans that choose not to switch to insurance with the Blues in New York, New York seeks to compel those plans to reverse their decisions to be self-insured. Those decisions are made by large and mature plans, like the Railroad Plans, for very good reasons. Such plans can predict with substantial accuracy what their benefits and related expenses will be in any given year, thus minimizing the need to insure against the risk that benefits and expenses will exceed available funds. On the other hand, becoming insured triggers the application to the plans of a long list of burdensome and costly state insurance laws and regulations, such as mandated benefit laws, mandated provider laws and premium taxes, from which Congress plainly intended, through the deemer clause in § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), to protect self-insured plans.[9]

In *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724 (1985), this Court recognized, and gave effect to, this legislative intent in a fashion directly relevant here. The Court held that a state law requiring that certain minimum mental health-care benefits be provided in insurance policies "relate[d] to" insured ERISA plans under § 514(a) but was "saved" under the insurance saving clause. The Court ruled, however, that the law could not be "saved" as to self-insured plans because of the deemer clause. In language closely in point here, the Court took note of Congress' intent to afford a special measure of protection to self-insured plans, an intent confirmed by post-ERISA legislative consideration:

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[9] The deemer clause provides, in effect, that state laws that "relate to" self-insured plans under § 514(a) of ERISA cannot be applied to those plans even if the laws are not preempted, as applied to insured plans, because they are laws "which regulate insurance" for purposes of the saving clause. § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).

"We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter.[25]

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[25] A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans: 'To the extent that [certain programs selling insurance policies] fail to meet the definition of an "employee benefit plan" [subject to the deemer clause], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these "products".' H.R. Rep. No. 94-1785, p. 48. A bill to amend the saving clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon." (Citation omitted.) *Id.* at 747 & n.25.

Congress' differentiation in ERISA between insured and self-insured plans and its determination to afford self-insured plans greater insulation from state regulation, all as recognized by this Court in *Metropolitan Life*, strongly support the view that the 13% surcharge as applied to self-insured plans "relates to" them for purposes of § 514(a) even if a contrary conclusion were reached regarding application of the surcharge to insured plans.

We should note here, as we did in the court of appeals without contradiction by petitioners, that, under New York law, self-insured plans apparently cannot avoid the 13% surcharge by hiring the Blues to administer their self-insured programs. The surcharge is imposed on all payments for services provided to patients "enrolled in a self-insured fund which provides for reimbursement directly to general hospitals." N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney Supp. 1993). The exclusion from the surcharge that favors the Blues is for payments for services "provided in accordance with *policies writ-*

ten" by the Blues. *Id.* at § 2807-c(1)(a) (emphasis added). Self-insured plans do not buy "policies written" by the Blues, or by any other insurer, and so make no payments to hospitals in accordance with any such "policy." Thus, even if administered by the Blues, self-insured plans are apparently required to pay the surcharge. They must become insured by the Blues to avoid it.

Even if the surcharge were not applicable to self-insured plans administered by the Blues, its impact upon national, collectively bargained, self-insured plans—like the Railroad Plans—would still be intolerable. To be sure, the plans would not have to buy insurance from the Blues to avoid the penalty, but their choice would remain unacceptable: pay the surcharge or appoint a different administrator in New York than elsewhere, even though uniform administration on a nationwide or multistate regional basis has long been a hallmark of interstate plan operations, as is the case with the Railroad Plans, and a practice collectively bargained, as is also the case with the Railroad Plans. Indeed, such uniform administration is likely to be the *modus operandi* for most nationwide health care benefit plans collectively bargained by management and labor, since it diminishes disparate treatment of plan participants and beneficiaries depending upon where they happen to live.

A plan with otherwise uniform administration that is forced upon pain of the surcharge to use a separate administrator—the Blues—in New York will be saddled with administrative burdens and inefficiencies that it does not now have. Among other things, such a plan would need to negotiate separate administrative service contracts, meld claims and other reports of separate administrators with separate information systems into a unified format, and make sure that the administrators interpret plan provisions—such as what services are medically necessary and what charges are reasonable and customary—in the same fashion.

And what if other states, following New York's lead, elected to penalize self-insured, collectively bargained, nationwide, ERISA-covered plans for failure to become insured with companies or to appoint administrators that for policy reasons these other states favored, companies and administrators that would not be the New York Blues and in all probability would be different from state to state? Surely, ERISA does not contemplate that a plan be faced with appreciable penalties in any number of states if it refuses to balkanize its structure and administration, since such a choice would threaten the uniformity that Congress in ERISA sought to promote. See 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams). The preemption clause was expressly designed to protect ERISA plans from efforts by states to require "the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990). See also *Shaw*, 463 U.S. at 105 ("By establishing benefit plan regulation 'as exclusively a federal concern,' (citation omitted), Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees.").

That plans like the Railroad Plans are the product of nationwide collective bargaining adds special force to their concern over the threat posed by the 13% surcharge to a comprehensive, uniform scheme of benefit administration. This Court has recognized that where ERISA-covered plans "emerge from collective bargaining, the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate" their terms. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). See also *PPG Indus. Pension Plan A (CIO)* v. *Crews*, 902 F.2d 1148, 1151 (4th Cir. 1990) (same). "As a subject of collective bargaining, [plan] terms themselves become expressions of federal law, requiring preemption of intru-

sive state law." *Alessi*, 451 U.S. at 526. The New York surcharge attaches to self-insured, collectively bargained, ERISA-covered plans because the collective bargainers chose not to negotiate the kind of arrangement that New York favors, *i.e.*, insurance with the Blues. Such a law certainly interferes with and intrudes upon the federally protected bargaining process.

Respondents have cited a number of decisions holding preempted state laws affecting ERISA plans in ways analogous to the impact of the 13% surcharge. We draw the Court's attention in particular to *National Elevator Industry, Inc.* v. *Calhoon*, 957 F.2d 1555 (10th Cir.), *cert. denied*, 113 S. Ct. 406 (1992), a case remarkably similar to the one at bar insofar as the applicability of ERISA's "relates to" clause is concerned. There, an industry association claimed that ERISA preempted a ruling by the Oklahoma Commissioner of Labor requiring employers to pay helpers on state projects at the higher wage level applicable to mechanics, unless the helpers had enrolled in a training program approved by the federal Bureau of Apprenticeship Training ("BAT"). The employers, however, funded an ERISA-covered, national, helpers training plan that had apparently not been approved by BAT. In a conclusion equally applicable in this case—one need only substitute "hospital rates" for "wages"—the court wrote:

> "We accept, as a general proposition, the state's right to regulate wages. But a wage law that provides an option favoring certain ERISA plans and benefits (BAT approved plans) over other ERISA plans and benefits [the employers' plan] is not a law of 'general application' and may be used to effect change in the administration, structure and benefits of an ERISA plan. If a state is permitted to use a prevailing wage scheme to single out and favor certain ERISA plans over other ERISA plans, the potential for abuse is great—a state could avoid ERISA's preemption provision and covertly disturb

> or alter ERISA plans. We believe that [the Commissioner's] ruling would discourage non-BAT approved ERISA training programs and encourage changes to [the employers' plan], a national employee benefit program. We hold that [the Commissioner's] ruling applying the state's prevailing wage law does 'relate to' an employee benefit plan because the ruling's effects on [the employers' plan] are not 'tenuous, remote or peripheral.'" 957 F.2d at 1561.[10]

B. The "Saving" and "Deemer" Clauses.

A state law "which regulates insurance" is saved from preemption by § 514(b)(2)(A) of ERISA. This insurance "saving" clause is limited, however, by the so-called "deemer" clause § 514(b)(2)(B). The deemer clause forbids states from deeming an employee benefit plan "to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ."

We agree with respondents, who have fully briefed the question of the applicability of the saving clause to the 13% surcharge as applied to insured plans, that under any "common sense" reading of the surcharge provision, see *Metropolitan Life*, *supra*, the saving clause does not come into play. The surcharge regulates hospital rates, not insurance.

That the saving clause does not save the surcharge from preemption as applied to self-insured plans is even clearer. The deemer clause is the beginning and end of the inquiry. It precludes application of the saving clause to a law

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[10] The court also noted that the Commissioner's ruling "has the effect, and possibly the aim, of encouraging participation in a specific type of ERISA plan (BAT approved apprentice plans) while discouraging participation in a different type of ERISA plan," *i.e.*, the employers' plan. 957 F.2d at 1559.

preempted by § 514(a) because it "relates to" a self-insured ERISA plan.

In *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), this Court concisely and clearly stated the governing principles in terms that control in this case:

> "[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation *'relate[s] to'* the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." 498 U.S. at 61 (emphasis added).

Courts of appeal have applied these principles consistently to preempt, as applied to self-insured plans, any state laws that otherwise regulate insurance. *E.g.*, *Tri-State Machine, Inc.* v. *Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994); *Electro-Mechanical Corp.* v. *Ogan*, 9 F.3d 445, 450 (6th Cir. 1993); *Travitz* v. *Northeast Dep't ILGWU Health and Welfare Fund*, 13 F.3d 704, 710 (3d Cir. 1994); *Hampton Indus., Inc.* v. *Sparrow*, 981 F.2d 726, 729-30 (4th Cir. 1992). The result should be no different here.[11]

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[11] This Court observed in *Metropolitan Life* that Massachusetts had "never tried to enforce" in connection with self-insured ERISA plans a state law that otherwise regulated insurance, thus "effectively conceding" that ERISA would preempt such application. 471 U.S. at 735 n.14. Moreover, as we noted earlier, *supra* at 12-13, in the court of appeals the Secretary of Labor expressly acknowledged that the deemer clause protected self-insured plans from application of the insurance saving clause in this case.

CONCLUSION

In closing, we briefly take note of the efforts of petitioners to depict the court of appeals' decision as inimical to sound public policy. They contend that its decision would radically undermine the authority of the states to determine how best to distribute the costs of health care. But certainly preemption affecting only state laws, like New York's 13% surcharge, that are imposed directly on self-insured plans by virtue of their core function—the provision of health care benefits—would have no such effect. Nor would the further extension of preemption to laws designed to force insured ERISA plans to turn to state-favored insurance carriers. Moreover, the wisdom of requiring those who need and can afford health care to bear a large share of those costs, as does New York, rather than subsidizing hospitals with funds from taxes that are not levied on health care general revenues, is at least questionable. In any case, this general subject has been at the heart of Congressional debate over the last year, a debate that most expect will soon be renewed. Congress, in the preemption provision of ERISA, has marked that debate as the appropriate forum for petitioners to make their case.

The judgment of the Second Circuit should be affirmed.

Respectfully submitted,

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